County of Los Angeles - Department of Mental Health
Chief Information Office Bureau

EFT Access Form
Legal Entity Data Extract Request Form for Enhanced File Transfer

Please Print All Information

Request Type

New ☐ Renewal ☐ Delete ☐

Please note: Your account will expire 1 year from account creation or renewal.

Instructions

Please complete this form in its entirety and return it to:

Department of Mental Health
695 S. Vermont Ave., 8th floor
Los Angeles, CA 90005
ATTN: Systems Access Unit

Processing can take up to seven (7) business days. Incomplete forms will not be processed. Original signatures only. Stamp signatures will not be processed.

Applicant Information

Print Applicant Name: _____

Last 4 digits of Social Security Number: _____ Day of Birth: _____ Logon ID _____

Legal Entity Number: _____ Legal Entity Name: _____

Telephone Number: _____ E-mail Address: _____

Requestor's Signature: _____ Date: _____

Requesting: ☐ Download Access ☐ Upload Access ☐ Confidential Oath Attached

Authorization

Chief Executive Officer

Print name: _____

By signing this form you hereby grant the above employee access to date provided by the Los Angeles County– Department of Mental Health for your organization. This data may included protected Health and/or claiming information, and is subject to protection as required by HIPAA standards and/or guidelines.

CEO Signature: _____ Date Completed: _____

Contact Person: _____ Phone Number: _____

Contact e-mail: _____

Notice: Upon user termination, it is the Legal Entity's responsibility to notify CIOB via this form. The danger in not terminating the User ID is the user maintains access t o your Legal Entity data and the potential to sabotage or misuse client's data exists.

For CIOB Use Only

☐ Approved ☐ Rejected Remarks: _____ Ticket #: _____

Info Security
Verifier Name: _____ Date Completed __/__ /___ Date to Network ____/____/____

Revised 7/20/2011

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
CIO BUREAU/INFORMATION SECURITY DIVISION

CONFIDENTIALITY OATH

The intent of this Confidentiality Form is to ensure that all County, Contractor, Pharmacy, Non-Governmental Agency (NGA), and Fee-For-Service (FFS) Network Providers employees are aware of their responsibilities and accountability to protect the confidentiality of clients' sensitive information viewed, maintained and/or accessed by any DMH on-line systems.

Further, the Department's Medi-Cal and MEDS access policy has been established in accordance with Federal and State laws governing confidentiality.

Welfare and Institutions (W&I) Code, Section 14100.2, cites the information to be regarded confidential. This information includes applicant/beneficiary names, addresses, services provided, social and economic conditions or circumstances, agency evaluation of personal information, and medical data. (See also 22 California Code of Regulations (C.C.R.), Sections 50111 and 51009.)

The Medi-Cal Eligibility Manual, Section 2-H, titled "Confidentiality of Medi-Cal Case Records," referring to Section 14100.2, a, b, f, and h, W&I Code, provides in part that:

"(a) All types of information, whether written or oral, concerning a person, made or kept by any public office or agency in connection with the administration of any provision of this chapter…shall be confidential, and shall not be open to examination other than for purposes directly connected with administration of the Medi-Cal program."

"(b) Except as provided in this section and to the extent permitted by Federal Law or regulation, all information about applicants and recipients as provided for in subdivision (a) to be safeguarded includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, agency evaluation or personal information, and medical data, including diagnosis and past history of disease or disability."

"(f) Requires agents of the State to abide by rules and regulations governing the custody, use and preservation of all records pertaining to administration of the Medi-Cal Program."

"(h) States "any person who knowingly releases or possesses confidential information concerning persons who have applied for or who have been granted any form of Medi-Cal benefits…for which State or Federal funds are made available in violation of this section is guilty of a misdemeanor."

Please read the agreement and take due time to consider it prior to signing.

I understand County, Contractor, Pharmacy, NGA, and FFS employees are prohibited from sharing their unique Logon I.D. and password with co-worker or other agencies.

Further, I understand County, Contractor, Pharmacy, NGA, and FFS employees are prohibited from obtaining, releasing, or using confidential client information from case records or computer records for purposes not specifically related to the administration of services and authorized by the state Welfare and Institutions Code (Section 14100.2).

Further, I understand violation of confidentiality of records or of these policies which are made for protection of confidentiality, may cause:

1. A civil action under the provision of the Welfare and Institutions Code Section 5330 or of Chapter 3 (commencing with Section 4330) of Part 1 of Division 4, for the greater of the following amount:
    1.) Ten thousand Dollars ($10,000)
    2.) Three times the amount of actual damages, if any sustained by the plaintiff.
2. Disciplinary action including **suspension or termination of employment**.

Further, I understand that the County will not provide legal protection if violations of these policies or procedures occur.

I hereby certify that I have read this form and the Department of Mental Health Policy on Data Security and Integrity of the Integrated System – Policy No. 302.18 posted at http://dmh.lacounty.gov/hipaa/index.html under IS Forms. I have knowledge of the requirements of state and federal confidentiality laws and will comply with its provisions.

I, the undersigned, hereby agree not to divulge any information or records concerning any client/patient without proper authorization in accordance with California Welfare and Institutions Code, Section 5328, et seq.

User's Name:_____ _____
Print Signature

Employee #: _____ Phone #:( ) _____ Ext._____

Pharmacy, FFS, NGA Legal Entity No. or
Provider #: _____ Provider Name: _____

Address: _____/_____/_____
City Zip

Service Area: _____ Date: _____

CIOB USE ONLY
Approved By: _____ Date: _____
MEDS COORDINATOR